Design for IHS Questions & Answers

Q: Will I remain eligible to get health care from the IHS?

A: Yes. The changes underway at the Indian Health Service (IHS) do not change your eligibility. Any person who is now eligible for service from the IHS remains eligible.

Q: Will the health care benefits provided by IHS change?

A: The re-design will not change the health care services that are available from the IHS. The goal is to assure that comprehensive personal and community based health services are accessible to all Indian people in a culturally acceptable manner. Some of the changes are to help control rising medical costs so that patient services can be continued and improved.

Q: Will restructuring of IHS alter where I go for care?

A: No. The plans do not involve opening or closing hospitals and ambulatory care centers. Many of the changes are behind the scenes - like reducing and automating paperwork, getting supplies more quickly and at less cost, and how the hospital or health center can work more closely with your tribe and local community to meet your health needs.

Q: Why is restructuring of the IHS necessary?

A: Tremendous challenges confront the future of the Indian health system. Big changes are underway in how Americans get and pay for their health care. Growing numbers of people are seeking health care. The population is older and age is a factor in what services are needed and provided. Medical costs are rising faster than incomes. More technology and more medical treatment is available at higher costs than ever before. There are more limits on government spending on health care. These changes put stress on the Indian health system, too. One of the primary concerns of the members of the Indian Health Design Team (IHDT) is to avoid having our health system overtaken by priorities different from those of Indian people. Although no redesign can eliminate all problems, we believe that it is better for us to deal with the needed changes than for others to make them for us.

Q: Are tribal operated heath programs affected?

A: Yes. No health care system is immune to the forces of change, especially rising costs. Today, tribes operate more than 40 percent of IHS programs. In some parts of the country, the majority of the Indian health care system is operated directly by tribes. In other parts, IHS continues to run the hospitals and health centers. Increasing contracting of programs is another reason the IHS must adapt.

Q: How does this affect the IHS in my community?

A: Few IHS hospitals and health centers do everything for themselves. They depend on support from Area Offices and other places to do some of the business side of work, such as finance and payroll, and for support to health care providers too. In other words, each local Indian health care facility is part of a bigger Indian health system. The forces described earlier are stretching the system more thinly. This is making it increasingly more difficult for the system to get needed support to the doctors and other health care providers in the community. Many of the proposed changes involve new ways to get this support work done so staff at hospitals and health centers can focus on the patient.

Q: Who decided the new design and how did you go about it?

A: Dr. Michael Trujillo, Director, Indian Health Service, appointed 28 people to the IHDT, most of whom are Indian and of whom 22 were tribal leaders or urban Indian representatives. The IHDT worked over a period of 24 months. We heard from technical experts and from Indian communities about the problems and needs in our health care system. After careful consideration, we made over 50 recommendations for change.

Q: What kind of changes?

A: After studying the problems, the members of the IHDT concluded that one design could not fit all the hospitals and health centers in Indian country. The differences among them are too great. We decided to focus on restructuring the support system on which hospitals and health centers depend for work not done onsite. The IHDT members devoted attention on how to supply the support services needed by hospitals and health centers. Most of the ideas relate to how IHS Area offices and headquarters should change to get this work done more effectively and at less cost.

Q: How will restructuring the support system change my hospital or health center?

A: The major change is that staff at the local Indian health facility will have more options for getting needed support services and more control over where to get it. When all the changes in the support system are completed, local staff will be free to shop for needed support from any acceptable source that meets the need at an affordable cost.

Q: Why is local choice so important for this work?

A: The idea of local empowerment is one of the key changes that members of the IHDT seek. The main point is that the people closer to you are more likely to serve you better than someone far away. When IHS was set up over 40 years ago, there was no alternative

to centralizing some of the work. Because most Indian hospitals and health centers are small, they can not afford to do everything alone. Area offices were set up to help do this work. This worked well and continues to work well in many ways. But the centralized way also means decisions that affect the local health program are often made far away. Even when decision makers are skilled and devoted to your interests, as IHS staff are, they are not as familiar with local issues as persons in the local health program. If the local officials have more responsibility, they can respond more quickly and flexibly to needs in your community.

Q: Is there a downside to the new approach?

A: There are some risks that must be overcome. Many Indian hospitals and health centers are geographically isolated and small. In other words, smaller Indian health programs do not have enough clout when acting alone. Unless we cooperate to share capabilities, knowledge, and buying power, our programs face higher operating costs, reduced leverage for fair prices, and becoming more vulnerable to competitors. To reduce risks, Indian hospitals and health centers need to cooperate to share capabilities and create a bigger voice together.

Q: How will this work?

A: Today, advanced communications technology offers the possibility to connect Indian hospitals and health centers together. As participants in an nation-wide Indian health network, each can access or share capabilities not available locally. By connecting with other Indian health facilities and all Area offices, local staff can choose among many options for getting support services. Each could access capability, support, and services available anywhere within the network. For example, an Indian health center in Oregon could use an expert radiologist in an IHS hospital in Arizona to read X-rays. An Indian hospital in Arizona could manage payroll through a personnel function in Portland Area. The limits of geographic location become less important and dependence on one source is reduced. In this way, Indian health programs can realize the benefits of cooperation, decrease dependence, and gain flexibility to fit local needs. The technology to do this exists. Investment in a nation-wide Indian health network to foster cooperation and collaboration is vital.

Q: What will happen to Area Offices? Will any close?

A: There are no plans to close Area offices, but they will be changing. The members of the IHDT did consider consolidating Area offices for a time. This idea was not supported widely in Indian country. Because the support system is stretched thinly in some Areas, we considered other ways to restructure this work. Our idea has three main points. We ask Area offices to form sharing arrangements for support services that each has trouble doing alone. In this way, Area offices backup one another. Second, we ask Area offices to transfer work that is better done locally to the local health program. How quickly this occurs depends on capability at the local program and also on when the Indian health network becomes fully operational. Third, we ask Area offices to change from controllers to suppliers that serve the local health program. Before, hospitals and health centers were subordinate to the Area office. The members of the IHDT see a new IHS in which the local programs take the lead while getting support from any acceptable source in the network.

Q: How will Areas approach these changes?

A: During 1997, Area offices are asked to hold inter-area work shops to identify opportunities for cooperation and sharing arrangements. The sessions will include Area offices, hospitals and health centers, Area health boards, tribal and urban Indian organizations. We ask Areas to follow this approach to assure broad participation in a local tribally-guided process.

Q: What will happen to IHS headquarters?

A: The members of the IHDT have recommended changes at the IHS headquarters to bring leadership at the top in line with empowering local Indian health programs. There are 3 key changes at headquarters. First, headquarters is reducing layers and streamlining structure by combining 132 components into less than 50 components within 3 offices. Second, selected components that pay or support field based health programs will be transferred to the field. Third, the IHDT has given headquarters new core functions that are very important for our new IHS. Because most of the resources for Indian health comes from the federal government, it is vital that IHS headquarters advocate for Indian health, advance our community based approach, support the nation-wide Indian health network, document our health needs, and furnish a strong voice for tribes and Indian people.

Q: When will all the changes be completed?

A: The restructuring of IHS headquarters components is scheduled for completion by the end 1997. The restructuring of Area level components is scheduled for completion by the end of 1998. The date for completing an Indian health network depends on funding availability.